V

THE MEDICAL SOCIETY FOR THE STUDY OF VENEREAL DISEASES

FOURTEENTH ANNUAL GENERAL MEETING

THE fourteenth Annual General Meeting of the Society was held at the Children's Medical Home, Coldharbour House, Waddon, Croydon (by kind permission of the Committee), on Saturday afternoon, July 13th, 1935. The President, Dr. Margaret Rorke, occupied the Chair.

The Hon. Secretary (Dr. E. R. Townley Clarkson) read an epitome of the Minutes of the last Annual General Meeting, which was approved, and the full Minutes were signed.

The Report of the Hon. Treasurer, Sir Frederick Menzies, K.B.E., showed that the total excess of the Society's assets over liabilities for the past year amounted to £397 14*s*. 3*d*. This sum does not include the half-share of the profits accruing from the publication of the JOURNAL for the half-year ending June 30th, 1935, if any.

The total excess of assets over liabilities for the previous year was £392 8*s*.

A unanimous vote of thanks was accorded to Sir Frederick Menzies for his invaluable work in administering the finances of the Society.

The following two new Rules were passed :—

(1) " The number of Vice-Presidents shall be limited to ten, including the Hon. Secretary of the Scottish Division (*ex officio*).

(2) " The three Vice-Presidents who have served longest in that capacity shall automatically retire at the time of the Annual General Meeting with the exception of the Hon. Secretary of the Scottish Division, but shall be eligible for re-election after the lapse of one year."

Dr. Margaret Rorke was re-elected to serve as President for the coming year.

FOURTEENTH ANNUAL GENERAL MEETING

PRESIDENTIAL ADDRESS*

By MARGARET RORKE, M.B.Ch.B., M.C.O.G.

LADIES AND GENTLEMEN,—It is with consciousness of the great honour that you have done me in electing me President of the Medical Society for the Study of Venereal Diseases two years in succession, and with a very great knowledge of my own unworthiness for such a position, that I venture to-day to offer you, not the Academic Presidential Address to which you are entitled, but a few short comments on cases and facts that have struck me during the years I have been doing Venereal Disease work among Women and Children.

It is because I believe that any small facts or oddities observed by any of us should be remarked upon, so that we may pool our experience and thereby increase our efficiency in this work, the scope of which is so wide that it is difficult for any one worker to be experienced in every branch of the work, that I produce these few observations.

May I quote a non-medical woman writer—Virginia Woolf—before I set forth my few ideas? "When a subject is highly controversial—and any question about sex is that—one cannot hope to tell the truth. One can only show how one came to hold whatever opinion one does hold. One can only give one's audience the chance of drawing its own conclusions as they observe the limitations, the prejudices, the idiosyncrasies of the speaker."

Now to mention a few things that I have noted, FIRST in the treatment of Syphilis, and Syphilis "contacts."

(1) When dealing with the wives and children of men suffering from G.P.I. the blood Wassermann and Kahn in my cases have been invariably negative—with one exception, and that a private case. What should one do? Should a Lumbar Puncture be done in these cases? Obviously that would be done in the case of a child or a woman showing nervous or mental symptoms? But if not—what then? Should they be discharged after one negative, or, say, two negative bloods, one before and one after a provocative injection? Should they have a L.P. done? or should they be asked to report annually for

* Based on an address delivered before the Medical Society for the Study of Venereal Diseases, July 13th, 1935.

retesting? My personal belief is that after two blood negatives, before and after a provocative injection, in the absence of suspicious signs or symptoms, they should be left alone.

(2) A small sign that I have noticed is that during a course of Arsenical injections, if an otherwise sensible patient becomes nervous causelessly and says she "dreads these injections," she is about to have arsenical poisoning, either slight or severe. I have ignored this symptom sometimes, and have always regretted doing so.

(3) We are all aware that a certain percentage of malignant cases, particularly where there is considerable destruction of tissue, give a strongly positive W.R., even when the possibility of previous syphilis can be almost totally eliminated. I have seen a case of inoperable carcinoma of cervix in a young married woman of twenty-four years, with a healthy child of two years, and a healthy husband with a negative W.R. This patient had a strongly positive W.R. and died, in a few months after radium treatment, of secondary cancer.

In contradistinction to this, I was asked to see a middle-aged patient in one of the Medical Wards, with a cross paralysis and a strongly positive W.R. and Kahn, who was doing very badly on Arsphenamine injections prescribed by the Hon. Physician. On Bismuth injections she improved out of recognition, got considerable power back in her hand, put on weight, and left the ward able to walk with the aid of a stick. She went to a Convalescent Home, but was sent back to the Medical Ward in three or four weeks, and died soon afterwards. P.M. generalised carcinoma of spleen, stomach, liver and brain. I quote this case purely for its interest.

(4) One sees, not infrequently, claims that babies are born "healthy and with a negative W.R." after the mother has had a few injections in pregnancy. If these few injections were the first treatment that the mother has ever had, that negative W.R. is of no value as the child is a syphilitic child and treatment must be pursued. A *minimum* amount of treatment in pregnancy is a whole set of Arsphenamine and one of Bismuth—less than that will lead to disappointment and disaster; and this of course must be followed by Arsenic injections to mother while the child is suckling, *or* a course of injections direct to the child if not breast-fed.

Now to consider discharges in women—Gonococcal and Non-gonococcal. Some chronic Gonorrhœas in women are due to chronic Salpingitis or even Pyosalpinx, where, on pelvic examination, nothing abnormal can be felt and no pelvic pain—or at most very slight and transitory pelvic pain—is complained of. I shall not be tedious and quote cases of definite Pyosalpinx that I have met, completely devoid of pain and of raised temperature or pulse-rate—I can only say that I have now had several such cases. And if one is tempted to regard the patient's chronic infection as due to re-infection and her general discontent and low spirits as due to the tedium of the treatment, never forget the possibility of Pyosalpinx. The only symptom that I know of which is *constant* is Menorrhagia; sometimes this does not continue—you may only hear of one early and excessively long period; the others are normal or nearly normal in many cases. But that is a warning signpost and should never be ignored.

Rectal infection with Gonorrhœa in women is more common than most people imagine or than I myself thought till recently, and so I draw your attention to the possibility of missing this focus. Symptoms of Pruritus and in cases of Gonorrhœa at once give rise to suspicion, and the lower end of the rectum should be carefully examined clinically and pathologically: some cases complain of diarrhœa and of mucus and blood in the stools, and before coming to the V.D. Department have been under the care of private doctors for the treatment of "Colitis." These have proved to be cases of Gonococcal Proctitis. In cases of Gonorrhœa of any duration in women, tests from rectum—films and cultures—should be done as a routine procedure. In cases of Arthritis the rectum must also be remembered as a possible focus of infection.

Finally, discharges in pregnancy, sometimes very purulent and offensive, are by no means always due to a recent or a chronic gonococcal infection. Pus and secondary organisms are found again and again: the blood C.F.T. is negative or perhaps very weakly positive in about 50 per cent. of the pregnancy discharges I meet with. Pruritus is an almost invariable symptom; and in this 50 per cent. repeated cultures are negative. These cases are due to a variety of causes—severe varicosity of

the legs and vulva ; lacerations at previous births ; a degree of Septicæmia following previous births or abortions : chronic constipation ; Trichomonas infection, and lack of scrupulous cleanliness. One therapeutic test of the greatest value—in addition to the pathological tests—is that in these cases, after one or at the most two adequate local treatments by the M.O., the patient's symptoms have practically disappeared and her local appearance is utterly different ; with a chronic Gonorrhœa after two or three treatments, the patient looks a little better—with the non-gonococcal cases the improvement is almost magical.

If I seem to labour this point it is for this reason : all of us appreciate the necessity for investigation of and treatment of purulent discharges in pregnancy, with a view to the prevention of Ophthalmia Neonatorum and puerperal sepsis ; and while any doubt remains in our minds as to the possibility of the discharge being gonococcal, we must test and re-test the patient. But during this time of probation it is we—the medical officers—who must bear the burden of doubt, never the patient. I insist on this point, because I have seen so many pregnant women driven nearly insane with the worry of waiting for a diagnosis where someone has lightly suggested to them that " it might be Gonorrhœa." It is easier by far to say to the patient " You have too much nasty discharge ; it must be cleared up for your own and the child's sake " ; and if it is necessary to make a diagnosis of Gonorrhœa to the patient later, that can be done with much greater effect ; the patient knows and can trust one, and is willing to continue treatment.

A final point—an elementary one, but not yet appreciated by everyone—is that a small percentage of these purulent discharges in pregnancy is due to a Syphilitic, not a Gonococcal, infection, and the routine taking of blood for W.R. and for a flocculation test is absolutely essential for every one of these cases.

This little paper will contain nothing new to many of you ; but in the hope that it may lead each one of us in due course putting forward anything a little out of the ordinary that we may have seen or may believe, I venture to present it to you.

" What is Truth ? " said jesting Pilate, and would not stay for an answer.

FOURTEENTH ANNUAL GENERAL MEETING

MANAGEMENT OF VULVO-VAGINITIS IN CHILDREN *

By D. KATHLEEN BROWN, M.B., B.S.

THE holding of the Annual Meeting of the M.S.S.V.D. here to-day is an honour for the Children's Medical Home, and as such is appreciated by the Chairman and the Committee. I feel very strongly, though, that I personally have nothing to say in opening this discussion that can be worthy of the occasion.

However, Colonel Harrison has suggested that this should be a practical meeting, and that a demonstration of our methods in dealing with the cases sent to us, and especially in avoiding cross-infection, would be of value to other practitioners.

A few words first on the origin of the Home may be of interest. From 1913, when specially trained workers began to visit the homes in crowded areas, the need for some place, other than a V.D. ward of a hospital, to which children suffering from gonorrhœa or congenital syphilis could be sent, became apparent.

The Federation of Children's Rescue Committees (now known as the Federation of Committees for the Moral Welfare of Children) decided to open a Home for girls between the ages of three and fourteen years. The Ministry of Health and the London County Council promised a substantial grant for maintenance, and when a suitable house came into the market the necessary purchase-money was raised by means of a mortgage and a loan.

The Children's Medical Home was opened in 1920, and the names of Mrs. Burge and Miss Bunyon, who is still our Chairman, must particularly be mentioned.

The Home stands in its own grounds of six acres. There is a garden and field for the children to play in, a vegetable garden and small orchard. You will shortly be looking round the Home and will see the children's chapel, dining-room, schoolroom, nursery and washroom, and the staff rooms, laundry and kitchens on the ground floor, and the children's dormitories, bathroom and treatment room on the first floor. The bedrooms and

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bathrooms for the nursing staff and senior domestic staff are on the first floor also, and the bedrooms for the junior maids are on the second floor.

Originally there was accommodation for twenty-seven girls between the ages of three and fourteen years ; but in 1928 the Home was enlarged and provision made for thirty-seven beds. Cases of gonorrhœa, because of their infectivity, are admitted in preference to cases of congenital syphilis, but as a rule there are from two to four congenitals in the Home. No distinction is made between the cases, because *every child is treated as infectious as long as she remains in the Home.* Children with other illnesses, *e.g.*, rheumatic fever or chorea which necessitate prolonged periods of nursing, mental defectives and small boys, are not admitted.

The nursing staff consists of the Matron or Superintendent, Miss Harvey, who had wide experience in the V.D. department at St. Thomas's Hospital before coming to the Home in January, 1924, one State-registered nurse and an institutional-trained children's nurse, assisted by a nursery maid.

The domestic staff consists of a cook and five young maids. There is also a gardener with an assistant, the Home being almost entirely self-supporting as far as fresh vegetables and fruit are concerned.

The gardener lives in the cottage at the entrance gate and he looks after the furnaces for the Home's central heating system. He also acts as lodge-keeper when parents visit the Home on first and third Sundays.

The school is under the charge of a fully qualified teacher. It is inspected annually by a Medical Officer from the Board of Education, as it ranks as one of the L.C.C. Special Schools. All children from five to fourteen years attend. The average number in school is twenty-six. Lessons are given in the field whenever the weather is good during the summer term. The usual holidays for council schools are observed.

There are two visiting Medical Officers. Dr. Scott-Russell Trick, who practices in the district, sees all children as soon as possible after admission, and is called in at any time in cases of general illness. The V.D. work is under my care and I see all cases once or twice a week.

A dental surgeon, Mr. H. G. Dumayne, inspects all the

children's mouths once every three months and carries out the necessary work.

The Home is run by a General Committee, the medical members of which constitute the Medical Reference Committee. It is inspected at intervals by Medical Officers of the London County Council.

Our cases are drawn mainly from the V.D. clinics of the Voluntary Hospitals and from the wards of the L.C.C. Hospitals. A certain number of cases are sent by Medical Officers of Health from other counties.

Under the joint scheme for the treatment of Venereal Diseases in London and the Home Counties a grant is made to the Home by the London County Council. The charge for children from the area covered by that scheme is 8*s*. 6*d*. a week. Parents are asked to pay what they can afford, but no child is ever refused or discharged for lack of payment. For children from other areas the full cost for maintenance and treatment, 26*s*. a week, is charged, with an additional 5*s*. a week for education if the child is of school age. The Medical Certificate and Application Forms are probably familiar to all here, also the Health Certificate, which is sent with the child on admission. Since the rule of taking throat and nasal swabs before admission was instituted in 1930, several carriers have been found and excluded, and there has not been an outbreak of diphtheria in the Home.

All children are isolated and rest in bed for the first two or three days after admission, and the throat and nasal swabs are repeated before they mix with the other children. One room of four beds is kept for isolation in addition to the working complement of thirty-seven beds.

The Home deserves the title, as it is definitely run as a home and not as an institution. Visitors who come on ordinary working days are usually impressed by the happy atmosphere and friendliness of the children.

The children wear a thick vest, knickers, warm dress and overall in the cold weather, and thin vest, knickers and overall in the summer. Bathing costumes and knickers are sometimes worn in very hot weather. Night-dresses are worn for bed. Pyjamas and combinations are avoided, as they have a tendency to produce irritation by friction. Pads or diapers are never used, for the same reason. If dark knickers have been provided by the

parents, then a large " patch " of white material is sewn inside.

The day's routine is as follows: Getting up at 7.30 a.m., breakfast at 8 o'clock, chapel for ten minutes, morning school from 9.30 to 12 noon, dinner at 12.15, afternoon school 2 to 4 p.m., tea at 4.30. The food is simple and as much fresh food is given as possible, *e.g.*, milk, butter, and fruit. The intervals are filled in with playing in the garden if fine, or in the covered playground or nursery if wet.

The " babies " of three to five years have garden or nursery play under the supervision of the children's nurse or nursery maid.

Daily baths are given with few exceptions. The time for bed after evening chapel is from 5.30 to 6 o'clock. The bigger girls, of course, do not settle for sleep at that hour, but obtain the necessary physical rest, which is part of the treatment. They sit up in bed and play with dolls, read or knit, etc., until the curtains are drawn, between 7 and 7.30 p.m. Occupation in bed is especially useful in the case of the masturbaters. These children are also encouraged to have a doll or animal in bed which has to be held with two hands on the pillow when going to sleep. The children's maid is on duty upstairs until 7.30 p.m.

Treatments are given at intervals during the day, the children coming up in small groups as they are called. The acute cases have the first swabbing of vulva before breakfast. The last evening treatments are given between 5.30 and 6.30 p.m. Temperatures are taken every morning.

Urines are tested at least once fortnightly for all gonococcal cases, and before each injection for syphilitic cases.

I am not going to deal with treatment methods in detail. Local applications to the vagina and urethra on dressed probes are made once or twice daily, and the vulva is swabbed and powdered as often as necessary to keep it free from pus and as dry as possible. Various lotions are used, *e.g.*, protargol 10 per cent. in glycerine, mercurochrome 5 per cent. or 25 per cent. in glycerine, $AgNO_3$ 1 per cent., acriflavine 1 in 500, S.T. 37, or neoreargon in dry powder form. Small glass specula are used for some cases or treatment is given through a Harrison's vaginoscope, with inflation of the vagina.

The rectum is frequently infected in children. It is most important to take tests in all cases and treat when positive, otherwise if neglected it may be a cause of relapse.

Sitz baths are given only as a preliminary to treatment in cases of profuse purulent discharge, as they are found to cause or increase incontinence of urine in some children.

Vaginal irrigations are rarely given except in cases where there has been some abdominal pain.

Vaccines are given in some of the chronic cases.

Treatment by means of ovarian follicular hormone was given a trial in 9 acute cases and 2 chronic cases during the summer and early autumn of 1934, but with 3 exceptions the results were disappointing.

Œstroform (British Drug Houses Ltd.) was the preparation given by daily injections of 200 to 900 units up to a total of 5,400 to 43,900 international units. No local treatment was given beyond swabbing the vulva with saline and powdering to keep it as free from pus as possible.

The 3 acute cases who responded satisfactorily were as follows :—

Case A, aged eleven years, received 11,500 units in nineteen days and was free from discharge after four injections. She completed six months' test for cure at hospital and returned to school in just seven months from the onset of the infection. She re-attended three months later and was entirely normal clinically and bacteriologically.

Case B, aged five years, received 13,000 units in twenty days and was free from discharge after fourteen injections. She remained well with negative tests in the Home for ten weeks after completion of treatment, but unfortunately failed to attend hospital for further tests.

Case C, aged four years, showed no improvement on injections of 200 units daily, but cleared satisfactorily on 500 units daily. Total dosage, 19,200 units in fifty-eight days. She remained normal with eight negative tests for twelve weeks and four days before being discharged from the Home. She attended the V.D. clinic, but after two negative tests defaulted.

Four acute cases cleared slowly, but relapsed clinically and bacteriologically from seven to sixteen days after the last injection.

The remaining 2 acute cases did not respond to the treatment and never became free from pus.

Four of these 6 cases did not clear up readily afterwards with local treatment, 2 in fact relapsing for the second and third times six months later.

The 2 chronic cases cleared satisfactorily clinically, but 1, although negative, did not give films free from pus. She remained in the Home for sixteen weeks' observation prior to discharge. She then defaulted from the clinic after an " unsatisfactory test."

The other child remained in the Home for only two weeks' observation, but attended hospital regularly, and twenty-two weeks later relapsed with a positive vaginal smear.

The disadvantage of this method of treatment in my hands was that acute cases which did not respond rapidly were infective, with much pus present for a longer period than with local antiseptic treatment.

It will be noted that of the 3 acute cases who did well in the Home only 1 was watched afterwards for a sufficient period to be certain that there was no likelihood of relapse.

There was a slight rise of temperature after the injections in 2 cases, but otherwise there were no untoward symptoms, *e.g.*, uterine bleeding.

A trial of œstroform by mouth has not yet been made.

Cases are kept in the Home as a general rule for at least two to three months' observation and tests without treatment before they are referred back to their own hospital for the completion of tests for cure. Two or 3 cases each year are kept for a minimum period of six months' observation until they can be pronounced cured after at least twelve sets of negative tests, a negative complement-deviation test for gonorrhœa, and a final set of films and cultures taken twenty-four hours after a provocative injection of vaccine.

All the pathological work for the Home is done in the V.D. laboratory at St. Thomas's Hospital under the direction of Dr. T. E. Osmond, to whom we are greatly indebted.

The average duration of treatment for 156 cases in the past four years (1931 to 1934) has been seventeen weeks, and the average duration of residence in the Home thirty weeks. Thirty-four per cent. of this series of 156 cases

relapsed while still in the Home after suspension of treatment.

The cases referred back to the V.D. clinics are followed up until they are discharged as cured, by means of medical reports which are kindly returned by the directors of the various clinics on the forms sent out from the Home every six months.

The number of relapses, of course, varies inversely with the length of preliminary observation previously undergone in the Home.

Two hundred and sixty-two cases of gonorrhœa admitted to the Home after March, 1928, have been followed up until discharged from hospital, with the following results :—

Discharged as cured without relapse	200, or 76·3 per cent.
Relapsed before discharged as cured	34, or 13 ,,
Remained negative but failed to complete final tests for cure .	10
Not attended hospital since leaving the Home	6
Reinfected	1
Transferred	1
Forms not returned . . .	10

The 13 per cent. relapses will be exceeded for more recent cases, as amongst those still attending hospital for tests there are no fewer than 14 relapsed cases.

This is not a picked series of cases who were discharged from the Home as " probably cured," but includes those who were discharged at the request of parents during treatment or without any adequate period of observation after suspension of treatment.

The special precautions adopted in the Home to prevent cross-infection of congenital syphilitic cases and reinfection of gonococcal cases are very rigid and are adhered to most strictly. They may be summed up as follows :—

(1) All cases admitted with an acute infection and profuse purulent discharge are kept in bed until the acute inflammation has subsided and the discharge has lessened. Rest in bed is not necessary in subacute or chronic cases, as a rule.

(2) No child is ever allowed in or on another child's bed.

(3) Each child is provided with her own flannel and bath towel upstairs, which are kept hanging on the back of her locker.

(4) Each child has her own face flannel, towel, tooth brush, and marked bag containing tooth paste, hair brush and comb, hanging on a peg marked with a letter or number over the basins in the wash-room downstairs.

(5) There are no lavatories in the Home for the children. Each child has her own chamber upstairs which is kept under her bed, and a second one downstairs which is kept in a special stand of pigeon holes, each marked with a letter or number in one part of the wash-room. Here there are several separate cubicles where the chambers can be used privately. At the further end is a sluice sink.

(6) The children are taught to wash their hands after defæcation and micturition. The children's nurse or nursery maid is always on duty in the wash-room morning and evening. Whenever she attends to any child she always washes her hands afterwards.

(7) The children's nurse or nursery maid wears a special overall and gloves for bathing the children. Faces are always washed in the basins downstairs and never in the bath. No small child is ever washed or dried sitting on the lap, but always in the bath.

(8) Baths are thoroughly swabbed with Lysol (1 in 3) and cleaned immediately after use in the case of every child in the Home.

(9) Mattresses are all covered with large rubber sheets and are not stoved between cases as a routine. Blankets are stoved and washed between cases.

(10) Sheets, pillow cases and towels are put straight into a copper of " persil " solution and boiled for not less than half an hour. Knickers and night-gowns are soaked in weak Lysol (1 in 50) before washing, and all except woollen ones are boiled. Vests and overalls are washed with carbolic soap.

(11) Clothes taken off at night are put on a chair by the child's bed. The nightdress is kept under the pillow during the day, dressing-gown in the

locker and slippers under the bed. Outdoor coats and hats are kept on marked pegs in the children's hall.

(12) Toys, dolls, etc., used upstairs are kept on the owner's bed or in her locker. They are kept separate and not shared with another child. The toys used downstairs during the day-time are shared in common among the children.

(13) All china, spoons and forks are washed and boiled in a special copper after every meal.

(14) Temperatures are taken in the axilla as a rule, rarely in the mouth, and *never* in the groin or rectum.

(15) The precautions taken in the treatment room for cleaning table, instruments, gloves, etc., are similar to those adopted in any clinic. For the treatment table small rubber sheets are used which are changed after each case and soaked in Lysol (1 in 40) for at least twenty minutes before being thoroughly dried.

The ritual of separate flannels, towels and chambers entails much work in training the children after their admission, and much supervision to ensure that there is no carelessness. It is a fact, though, that after the children have been in the Home for a short time they are so well drilled that they would not think of using any towel, etc., other than their own. Occasionally a new child is difficult and special means have to be adopted to make the ritual attractive, *e.g.*, one small child was given a ribbon to tie on the handle of her chamber! This proved so popular that coloured ribbons on handles are now the fashion for several of the younger children.

The Home is most fortunate in having a Matron whose work is invaluable. The small nursing staff has not been changed for eight years, and is under her direct supervision, so that none of the precautions is ever relaxed.

It is owing to this rigid routine that we are able to state that no child admitted to the Home for treatment of congenital syphilis has ever acquired gonorrhœa.

I am very conscious of the many gaps in this summary, but any questions will be answered when going round the Home. I hope now to learn much from the discussion, and if some pronouncement could be made from this

meeting on standard tests for cure in cases of gonococcal infection in children, it would be of great value to the profession.

Discussion

THE PRESIDENT thanked Dr. Kathleen Brown very much for her delightful paper. All who were engaged in V.D. work would like to send their children patients to this Home, after seeing the healthy condition and the happy spirits of the patients. She herself had never sent a child here from the Royal Free Hospital without having the satisfaction of seeing her come back at the top of her physical and mental health. That was due not alone to Dr. Brown, but, as the latter had said, also to her admirable nursing staff.

She invited remarks particularly on tests of cure.

Dr. MORNA RAWLINS said that Dr. Kathleen Brown also worked at the V.D. Clinic at Guy's Hospital and the same standard of cure was observed there.

The speaker did not think it was safe to relax these tests at all, though they might perhaps with advantage be tightened up.

There had been cases at Guy's of children relapsing after six months with negative tests. She would be glad to hear the views of other members as to whether they considered the standard of cure could be raised.

Dr. DAVID NABARRO said he was sure all present had listened with very great interest to this paper. As he had been looking after cases of vulvo-vaginitis for the London County Council and neighbouring councils, at Great Ormond Street Children's Hospital, for a number of years, he would like to offer a few remarks.

With regard to the tests for cure there, while the œstrin treatment was being given, the children were tested daily in order to see how rapidly the gonococci disappeared, how soon the leucocytes disappeared and the epithelial cells arose. Sometimes daily tests were carried on for as long as three, four or more weeks. They carried out daily swabbing in the ward, and after the tests had been negative for a fortnight the patients were allowed out on probation. Before going out, however, they were given a dose of vaccine, generally 300 millions, and a swab was taken the day afterwards and on the next day. They were then plugged for twenty-four hours with a gauze

plug soaked in glycerine. The plug was removed after twenty-four hours, when it usually was coated with pus and was offensive ; it was examined for gonococci. The late Dr. David Lees stressed the importance of this test, and the speaker had since done it in every case. Sometimes it would revive gonococci. The complement-fixation test was done on the child's entry, also when it went out, but in his hands at Great Ormond Street the complement-fixation test for children had not been very helpful. The children were then sent to the Out-patient Department, and had to report to the clinic. They were told to come at the end of a week, when they were swabbed ; again at the end of a fortnight, then at the end of three or four weeks, and after that once a month. The mother was instructed to bring the child at once if the discharge should recur. Usually there were no relapses after once a child had been discharged as cured.

With regard to treatment with the œstrin preparation, this had been obtained from the Organon Laboratory. Various methods of employing it had been tried, and the oral administration had been found to be as efficacious as injections, and the children preferred the oral administration, in fact they liked the tablets. But far bigger doses than those previously recommended had been used, and the only sequel was a slight enlargement of the breasts. One or two of the children bled a little, in the early days, but when the œstrin was suspended the bleeding stopped. He had seen no permanent ill-effect from the use of the big doses. At his clinic 3,000 to 4,000 units a day were given by the mouth, and it was continued for four or five weeks. The purulent discharge cleared up quickly. They also gave daily irrigations, in order to flush away the material which accrued. Tincture of iodine, a drachm to the pint, was used for this. These measures resulted in a curtailment of the period of treatment. There had been no relapses, except bacteriologically ; there might be occasional re-infections after the children returned home. Why should a child relapse after being ten weeks free ? He was at a loss to explain such cases when on examination the rectum and urethra were found to be free from gonococci.

Dr. T. ANWYL DAVIES remarked that, unfortunately, he had had a rather extensive experience of vulvo-vaginitis for some time past, too extensive for his happi-

ness. Smears were of very secondary importance in comparison with cultures. He considered that cultures should be taken regularly. He could not agree with what Dr. Nabarro said as to the value of the complement-fixation test in children. He had seen a number of cases in which it had been negative after treatment, and when the treatment was stopped the complement-fixation relapsed accordingly and in agreement with the cultural tests of material from the vagina. He regarded the complement-fixation and cultural tests as all-important.

Dr. Nabarro had raised the question of the use of œstrin. When that gentleman started the œstrin treatment he kindly told the speaker about it, and he followed suit, hoping for cures without relapse in a short space of time. Various doses were tried on a dozen children, and after injecting big doses it was amazing to see the engorgement of the breasts, and a ward of children who were masturbating practically all day long. But these effects ceased as soon as the œstrin was discontinued. With the reduction of dose to 50 units injected daily, the experience agreed with that which Dr. Nabarro had related. As long as œstrin was being given the tests remained negative. The majority of the cases, however, relapsed pathologically, but not symptomatically, as soon as the œstrin was stopped. It was a most disappointing experience.

NOTE ON THE CHILDREN'S MEDICAL HOME

THE Home is a very modest Home originating out of the difficulties of the Federation of Children's Workers as to where to place girls of school age who were infectious yet not cot cases. These children were a danger in their own homes, it was practically impossible for their mothers to take them to clinics for daily treatment, and being debarred from school suffered enforced idleness.

The Chairman of the Federation of Children's Rescue Committees, Mrs. Burge, wife of the late Bishop of Southwark, decided to open a Medical Home, though the Federation as a Federation refused to take the risk. The Home therefore from the first has had its own governing body.

It is a Church of England Home, but takes in members